UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WILLIAM DIXON, et al.,

Plaintiffs,

v. Civil Action No. 74-285 (NHJ)

ANTHONY WILLIAMS, et al.,

Defendants.

COURT MONITOR'S NOTICE OF SUBMISSION OF REPORT

Court Monitor, Dennis R. Jones, respectfully submits the attached Report to the Court pursuant to the Court's May 23, 2002 Order requiring regular reports concerning the status of Defendants' compliance with the Plan.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that copies of the foregoing COURT MONITOR'S NOTICE OF SUBMISSION OF REPORT and the Court Monitor's REPORT TO THE COURT were served by first class mail, postage prepaid, this 21st day of July, 2003 upon:

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REPORT TO THE COURT

Court Monitor
Dennis R. Jones

July 21, 2003

I. Context

On October 23, 2002, the Court approved the Monitoring Plan for the period October 1, 2002 through September 30, 2003. The Monitoring Plan encompassed three primary areas for review during this period:

A. Development of baselines and relevant benchmarks for each of the approved categories in the Court-approved Exit Criteria and the subsequent development of Court-approved performance targets for the identified categories in the Exit Criteria.

B. Monitoring the development and implementation of both the administrative and service functions outlined in the Court-ordered Plan.

C. Monitoring the occurrence of events or issues that may significantly impact the implementation of the Court-ordered Plan.

This report provides updates on the status and/or progress in each of the above areas, highlights identified barriers to progress, and makes recommendations for overcoming such barriers.

The May 22, 2002 Court-approved Consent Order called for a report twice per year. This is the second of two formal monitoring reports to be submitted in 2003; the first was submitted on January 13, 2003.

II. Findings Regarding Exit Criteria

The Court-approved Exit Criteria tasks for this year fall into three categories: 1.) The review of DMH-developed consumer satisfaction methods and consumer functioning review methods, 2.) The development of baselines and required performance levels for consumer services reviews, and 3.) The development of baselines, relevant benchmarks, and required performance levels for the measurement of system performance. This report will speak to progress as it relates to each of these areas.

A. Consumer Satisfaction Method(s) and Consumer Functioning Review Method(s)

The Court-approved Exit Criteria call for the DMH to develop method(s) to assess consumer satisfaction with services and to assess consumer functioning. The Exit Criteria describes the role of the Court Monitor as one of review and approval of such proposed methods for consumer satisfaction and review of proposed functional

review methods. For both areas, the Court Monitor will assess the degree to which the results of these methods are used within the DMH's overall quality improvement process.

As of this Report, the DMH has not proposed specific methods in either area. Rather, it has proposed a process by which to get to specific methods. In the case of consumer satisfaction methods, the DMH has proposed and begun an RFP process that intends to contract out to an independent consumer organization the task of assessing "consumer satisfaction about mental health services and systems support by collecting data through focus groups and interviews, and making recommendations for changes as needed." The basic premise behind this approach is that a consumer-run organization will be in a better position to capture accurate consumer perceptions. The state of Pennsylvania (and other states) has adopted this approach with apparent success.

The RFP would require three major tasks to be completed by the end of the first year. These include: 1.) The conducting of consumer focus groups in two or three specific areas for inquiry for measuring satisfaction, 2.) Conducting individual consumer surveys in the same two or three areas – utilizing specific tools to capture information, and 3.) The development of a longer-range plan for consumer satisfaction based upon the experiences and knowledge from year one. The timeline put forth is that the first survey will be completed by December 1, 2003, with information disseminated by January 31, 2004. DMH, under this approach, would report the methodology and the results to the Court Monitor by January 31, 2004.

Via separate memo, the DMH has proposed an approach to developing consumer functioning review method(s). DMH acknowledges that it has not placed emphasis on this issue due to the fact that energies and focus have needed to be on getting basic services and systems in place.

The DMH, by way of process, proposes to put together a small work group of consumers, family members, provider agency staff and DMH staff to look at various approaches. The overriding questions have to do with measuring functioning levels for all consumers (or just a sampled population) and whether existing methodologies (e.g., the Community Services Review) could be used or adapted to provide an assessment method. The DMH intends to have a proposed model by the end of September 2003, to be implemented in the first quarter of FY 2004 (October – December, 2003).

As relates to both the Consumer Satisfaction and the Consumer Functioning proposals, the Court Monitor is in general agreement with

the planned approaches. The only condition would be that the DMH (via the Director and key staff) keep the Court Monitor informed of progress and proposals during the development stages, so as to avoid potential differences of view in the ultimate approaches proposed. The Court Monitor will continue to report formally on each of these areas in his semi-annual reports to the Court.

B. *Development of Baselines for Consumer Services Reviews*

Since the time of the January 13, 2003 Report to the Court, the Court Monitor, via contract with Human Systems and Outcomes (HSO), has completed pilot reviews for both children/youth and adults; based upon the results of the pilots, the first protocols were agreed upon between the Court Monitor and DMH.

As planned, the initial year one baseline reviews for children/youth and adults were conducted using these protocols in March 2003 for children/youth, and in May 2003 for adults. DMH did provide staff to be trained as reviewers so as to conduct approximately 50% of the total reviews. DMH staff were also extremely helpful in providing logistical support for the reviewers (e.g., travel to interviews, assistance in scheduling, etc.). Stratified random samples were selected for both the children/youth and adult reviews using three variables – provider agency, age, and the individual's level of need. The targeted sample sizes for both reviews was 36. In the case of the children/youth baseline, the final number surveyed was 35, and for the adult survey it was 29. HSO has completed its final report to the Monitor for children/youth, which is attached to this report as Attachment A. The Court Monitor, for purposes of this report, would like to underscore and highlight several of the findings and recommendations from HSO, as follows:

1. As part of the sampling methodology, it became apparent that children/youth from the District who are placed into residential treatment centers (RTC's) are not enrolled in any of the DMH CSA's – even for case management. This created concerns for the sample itself, namely the difficulty in finding cases that were in the "high need" category. It also raises a larger systems concern if DMH, as part of the evolving role, does not play a critical role in the services planning and placement (or diversion) into RTC's, readiness for return to community and coordination with RTC's and families while children/youth are in RTC's. The DMH, in response to the CSR Report, has begun the process necessary to achieve this objective. While it is more complicated than the process of enrolling adults, DMH has indicated that it plans to

complete the planning process by August 15, 2003 – with an expected timeframe for full enrollment of 3-6 months.

2. From the experience of HSO during this baseline, it is evident that there is a significant gap between the number of children/youth who are enrolled through the DMH's eCura system and the number who are actually receiving services. This problem became apparent because one of the requirements to be able to include a case in the sample was that the case must be active – defined as having received at least one service. It is not clear to the Monitor whether this gap reflects flaws in the data management system, the disenrollment policy, or flaws in the clinical practice standards – or all three.

The DMH, based on the findings, has begun work on a draft policy that allows providers to disenroll consumers not being seen. When completed, this will replace the existing policy that does not allow disenrollments.

3. In terms of overall performance during the baseline review, it was encouraging to note that during this first review, the overall status of sampled cases was 77% "favorable" (rating levels of 4, 5, or 6). Many positive examples of quality care were noted by the reviewers. However, a closer examination of the sample revealed that (in addition to the system not enrolling more difficult children/youth) the older and more complex cases do not do well in the current system. The overall children/youth status was just 30% favorable for children/youth who were lower functioning and the overall systems performance was only 10% for lower functioning cases. The pattern is clear that younger and higher-functioning cases do pretty well in the current system; older and lower-functioning do very poorly. The Court Monitor – recognizing the early developmental status of the child/youth system and the many efforts underway – would nevertheless want to underscore and concur with the HSO statement that: "the systems of care has not yet developed so it can perform consistently for more complicated or complex children and families. To be effective, a service system should work most of the time for most of the people receiving services. The current system works sometimes for the lower-need children and less often for those whose needs and life circumstances require more intensive services, more interagency coordination and more individualized treatment programs. These are the children who are most in need of receiving services according to the principles of the systems of care and these are the children who are currently not receiving them."

The final report on the adult baseline review is expected in July 2003 and will be submitted under separate cover to the Parties and to the Court.

The Court Monitor will be meeting with DMH leadership and HSO in late July 2003 to review the overall experience for year one reviews (child/youth and adult) with the intent of making needed modifications for year two. It is clear there are significant logistical and data consistency issues to be resolved. It is also clear, however, that the DMH is very interested in the Quality Services Review model and would like to find ways to internalize, reinforce, and measure for itself this overall approach.

C. *Review of Baselines for Measurement of System Performance*

Since the time of the January 13, 2003 Report to the Court, there has been important progress, though not full resolution, on the fifteen (15) systems performance measures as approved as part of the first Exit Criteria. The Court Monitor and the parties have agreed on operational definitions for each of the 15 areas. This agreement includes the general methodology for measuring each of the areas.

There are two outstanding issues. First, while there has been resolution on the baseline period for 11 of the 15 performance measures, the appropriate baseline period for the remaining four have not been finally resolved — although discussion with the Court Monitor and the parties would suggest that resolution is possible. The DMH has agreed to send the Court Monitor a detailed letter describing the proposed earlier time periods for these four, plus the specific data sources that would provide comparability of baseline data to post October 1, 2002 data.

The second issue that remains unresolved centers around the reliability of data collections for at least five of the system measures. Currently, the DMH is collecting information on these items via a manual monthly reporting process and not through its electronic eCura system. The manual reports do not provide an unduplicated count and are not individual-client specific. Hence, there is no way to verify the data submitted. The proposed solution would seem to be to include these five as required data fields in the electronic system. As of the report, the DMH is exploring revisions to its eCura system to provide this capability.

D. Establishment of Court-approved Levels for Consumer Review Performance and Systems Performance

The Monitor's Court-approved Monitoring Plan for FY 2003 anticipated recommendations to the Court by August 31, 2003 on both DMH performance levels for consumer reviews (child/youth and adult) and the fifteen system performance measures. The parties and the Court Monitor have agreed to target this date. It is clear that considerable work remains. The Court Monitor has been meeting regularly (every two weeks) with DMH leadership and staff to work through the multiple issues involved in developing dependable baseline data and relevant benchmark data from other urban jurisdictions. The DMH has put forward a proposed conceptual approach to these issues, to which the Court Monitor will be responding in the near future. It is anticipated that both available baseline data and relevant benchmark data will be forthcoming by the end of July 2003.

III. Findings Regarding Development and Implementation of Court-Ordered Plan

A. Review of the Development and Implementation of Key Systemic Authority Functions

1. Quality Improvement and Provider Oversight

The primary authority for quality improvement and provider oversight is vested in the Office of Accountability. The Office of Accountability has developed capacity across a spectrum of key authority functions as required in the Court-ordered Plan and the Mental Health Establishment Act of 2001. These include the functions of certification, licensure, quality improvement, and policy development. The DMH has hired or identified leadership people in each of these areas, as well as the overall Director of Accountability who reports directly to DMH Director. Hence, the basic infrastructure (legal and policy framework) and the staffing structure are now in place.

As relates to provider oversight, one of the first questions is how does a provider who desires to be certified (as a Core Service Agency (CSA), sub-provider or specialty provider), achieve this status. The DMH has developed and implemented a comprehensive set of standards, application processes, training aids and survey processes for providers seeking certification. To

date, there are 14 providers certified as CSA's and 2 as specialty providers. Certification is for a two-year period with recertification required before the end of the two years. In addition, there are currently 14 providers seeking certification either as CSA or specialty provider. All indications are that the certification process is thorough, objective and timely. This is consistent with the Monitor's Report to the Court of January 13, 2003. It is also true that considerable DMH and provider effort in the past year has gone into bringing new agencies online and working through the multiple challenges of enrollments, treatment authorizations, and payments for authorized services. One of the major concerns has been the tension between providing timely payments to providers and ensuring (as the delegated Medicaid agent) the reasonable accuracy of enrollments and services being paid. The Division of Quality Improvement has taken on the direct responsibility to conduct medical record audits on the twelve (12) CSA's that were certified at that time (late 2002 or early 2003). As might be expected, there was wide variability among the CSA's in terms of the twelve items that were measured. The major focus in this first audit has been to ensure that there is a treatment plan and that progress notes match to services actually billed. The outcome of these benchmark audits is that, since no CSA obtained a perfect score, all were required to develop a Corrective Action Plan (CAP). Generally, corrective action plans require that CSA's develop a self-audit capacity as well as develop specialized staff training in deficient areas.

One of the other major systemic issues as it relates to provider oversight is the issue of compliance with MHRS standards and the DMH's regulatory roles vis-à-vis providers as consumer or advocacy complaints are brought forward. There are several questions that ensue: Does the DMH have adequate policies and regulations in place? Are the rules and standards that are in place being enforced? Does the DMH have in place the correct "fit" between the issues at hand and the response? As with other areas, the answers to these questions are evolving. In general, the DMH is closing the regulatory "holes" it has identified — e.g., draft rules are in process for: Decertification of a DMH Certified Provider; Standards for Participation of Residential Treatment Centers for Children and Youth; and the rules for use of seclusion and restraint by mental health crisis emergency programs. The question of enforcement of existing rules seems to point to the overriding reality that most of the DMH focus in year one has been around getting CSA's up and functioning. Of late, the DMH is moving to differentiate its response to consumer complaints and take a more hands-on response. The DMH has recently – via the certification

division – done several in-depth reviews in direct response to repeated complaints regarding a given provider or providers. The results of these reviews have been encouraging in the sense that systemic issues are being identified and concrete remedial actions across several providers have developed. This kind of DMH response is different from the process for singular and distinct grievances or unusual incidents which will be discussed in Section III. A. 8. below. The whole area of DMH provider oversight (or lack thereof) has been a source of great concern to many in the advocacy community, so this recent response is viewed as hopeful.

One of the particular areas of oversight concern is the whole area of community residential facilities (CRF's) as part of the Mental Health Reform Act of 2001. The DMH took on this responsibility for 167 facilities, which includes certification and oversight. Historically, the oversight of CFR's has been sadly lacking. The Office of Accountability has moved aggressively to fill these policy and oversight gaps. Over 160 plans of corrections for identified deficiencies have been required of CRF's and over $18,000 of fines have been levied for infractions. The Division of Licensure is now staffed with four inspectors, who investigate complaints and unusual incidents in CRF's and then require a plan of correction if the complaint is substantiated.

In addition, the Division of Licensure (of the Office of Accountability) has taken on the responsibility to inspect an additional 450 residences that are classified as "supported independent living" to ensure that these facilities meet basic health and safety standards. This has been identified as an entirely unregulated area. The DMH published emergency regulations in early 2003 to address this gap. The Licensure staff are implementing the new regulations and are training provider staff on how to conduct quality checks for their consumers. DMH will then do a 100% review of the quality checks.

The DMH has developed and approved an overall Quality Improvement Plan. The Monitor has reviewed this Q.I. Plan and finds that it is conceptually sound in its scope and proposed structure for implementation. It is clearly a multi-year framework for a comprehensive Quality Improvement system. However, the issues for the Q.I. Division are more practical and immediate than conceptual or longer-term. Namely, the Q.I. Director has to-date been largely focused on the immediate needs to oversee the Medicaid benchmark audits referenced earlier, supervise the consumer rights advocates, and begin to implement the new major unusual incidents (MUI) policy that DMH has put in place. As the

Director of the Office of Consumer and Family Affairs (OCFA) is hired, it has been decided that OCFA will manage the processes for complaints and grievances; the review of major unusual incidents will remain with the Division of Quality Improvement. The Q.I. Director has developed a proposed staffing structure, which he has recently been given the approval to implement. The Q.I. Director intends to meet monthly with the Q.I. Directors of the CSA's, but this is still uncertain pending other priorities. Also in the wings is the creation of an overall Q.I. Council to steer and energize systemic Q.I. initiatives.

It will be key in the next phase of DMH development to move the basic Q.I. Plan forward to ensure that quality does, in fact, get built into the lifeblood of the authority and all of the providers.

2. **Planning and Policy Development**

The principal staffing support for the planning function is vested in the Office of Organizational Development, but in truth the planning function occurs at different levels of the organization. At the macro level, the DMH does have an approved two-year strategic plan and is also in the first year of Performance-Based Budgeting (PBB). DMH leadership staff have received training regarding the implementation of PBB, which is being rolled out through all of District government. PBB is intended to tie the basic concepts of resources (budget) to strategic objectives and the accomplishment thereof (performance). The DMH Director's performance contract with the Mayor (and the Director's performance-based agreements with key staff) further reinforce the notion of achieving specific performance levels.

It is the multiplicity of DMH initiatives, advisory groups, inter-agency councils, and ad hoc groups that creates confusion for some as to who is planning for what. Given the current state of development, this may be inevitable, but it does suggest the continued need for clarity as to roles, relationships and processes in the overall planning effort. The DMH, internally, has recently completed a "crosswalk" of requirements as a way of creating common understanding of responsibilities and priorities.

The DMH does have a structured process for identifying and developing needed policies. The Director of Accountability and the Director of Systems Delivery have co-chaired a policy development committee, which meets on a regular basis with a structured agenda, minutes, etc. The policy development committee oversees the process for both policies (internal to

DMH) and rules (which can and do apply to all contracted provider entities. The identified need for a rule or policy can come from any committee member or from outside persons. The Office of Accountability has an assigned staff person who often does initial drafting on proposed policies. The drafting of rules – depending upon the issue – often emanates from other people – e.g., the General Counsel. Proposed policies routinely go to impacted parties for review and comment before put into final form and approved by the Director. The process of adopting rules is governed by D.C. codes and involves a much more formal process of promulgation, public review, and legal sufficiency review by corporation counsel prior to final approval. District law does allow for emergency rule making under certain conditions.

Overall, the process of developing needed policies and rules appears to be working well. The process is clear and consistent to people within the Department and also to those outside.

3. **Delegated Medicaid Responsibilities**

The core agreement setting up the delegation of Medicaid responsibilities for the Medicaid Rehabilitation Option (MRO) to DMH was effectuated during the Transitional Receivership period, but was further refined and delineated by DMH and the Medicaid Agency (MAA) on February 13, 2002. The basic delegation model provides that DMH will plan for, regulate, and pay the local match (30%) for all MHRS services that are eligible for Federal Financial Participation (FFP) through the Medicaid program. MAA, through this agreement, claims the Federal share (70%) after payment has been made to the provider by DMH and DMH has forwarded the claim to MAA. MAA, upon receipt of the Federal portion, then forwards these funds to DMH.

The basic delegation model as outlined in the Court-ordered Plan appears to be working. The working relationship between DMH and MAA has been a positive and productive one. An example of this positive working relationship occurred when MAA intervened with the new fiscal intermediary to help solve computer interface problems that were occurring for DMH and the intermediary.

There have been multiple issues for DMH to deal with as relates to MRO development – most notably in the area of creating "clean" claims and in creating audit capacity at both the DMH and provider level. It would appear, however, that MAA has been fully supportive of these developmental efforts and the basic trust between the two agencies is good. The initial delays in the flow of

FFP to DMH appear to be resolved, as MAA is now paying on a scheduled basis.

It is also noteworthy that DMH is directly involved in the selection, provider development and ongoing collaboration on all prepaid health plans as administered via MAA. The DMH role is specific to the mental health/behavioral health components of those plans.

4. **Systems of Care Management**

The DMH has clearly embraced a systems of care approach in its overall vision, mission, goals, services and polices for the agency. The organizational structure itself reflects a commitment to the systems of care approach. The Delivery Systems Management arm of DMH has – as its core mission – the development and implementation of a cross-agency and recovery-based approach to adults with serious mental illness and a family-centered and cross-agency services model for children and youth. This systems of care philosophy is reflected throughout all of the major efforts the DMH has undertaken, including its commitment to a consumer choice model, the extensive attention to continuity of care issues and the critical need to interface across traditional agency boundaries (e.g., housing, employment, schools, etc.)

The major barriers to moving these models to practice have been at least twofold. First, as discussed elsewhere, the DMH and the provider community have been heavily concerned in the first year with working through basic enrollment and payment systems. This mammoth undertaking has consumed much of the energy and focus at all levels. The second barrier has been the change in leadership within Delivery Systems Management – most notably at the Director of Delivery Systems Management level and the Director for Adult Services. Both of these positions are currently interim. Inevitably, leadership changes cause discontinuity and at best slows needed momentum. It is also critical that the provider and advocacy community have confidence in the direction and stability of these systems-changing initiatives.

Despite the above, the current Delivery Systems Management staff are moving forward on many fronts. Specific efforts will be reviewed in sections IV and V of this report. It is encouraging to see the outline of an overall delivery systems business plan – which delineates the multiplicity of tasks, timelines and responsibilities across the entire systems delivery area. It is evident that the next year will be consumed with the difficult task

of building systems of care models that are routinely practiced at the consumer and family level.

5. **Children/Youth and Family Services**

The Court-ordered Plan noted that, in a very underdeveloped community system, the whole area of children/youth and families was the most underdeveloped. Hence, it is very encouraging to see the number of children/youth initiatives that DMH has undertaken in the past 18 months. The initiatives were highlighted in the Monitor's January 13, 2003 Report to the Court and include the MAPT process for assessing and diverting high risk kids; the $8 million Federal grant to help develop a viable community-based system for children and youth with serious emotional disturbance; the school-based initiative, and the $2 million Juvenile Justice diversion grant for 75 high-risk youth. These initiatives will be discussed further in Section V of this report. Overall the number of children and youth being served through DMH services continues to grow. The January 13, 2003 Report to the Court indicated there were 1,154 children/youth being served as of December 2002. That number (as of May 2003) now stands at 1,891 total enrollments for age 17 and younger consumers in all of the CSA's. While these numbers are still far below need estimates, they reflect continued and critical development of services capacity. It is also noteworthy that new child-serving agencies continue to apply as potential CSA's. There are currently at least four such agencies in the application pipeline.

It is apparent that the DMH has taken a leadership role in D.C. government in building true systems of care. The sub-council of the Mayor's Intergovernmental Youth Investment Collaboration, which is mandated as part of the enabling legislation for DMH continues to meet on a regular basis and has taken a visible leadership role in supporting cross-agency efforts. The new philosophy clearly embraces the integral role that families must play in all services planning and decision-making. The DMH, as an example, took the lead in recently bringing together over 70 individuals from the various local child-serving agencies, child advocates, providers and interested community organizations. This retreat will lead to an updated strategic plan for systems of care development for children and youth in the District.

6. **Consumer and Family Affairs**

The Office of Consumer and Family Affairs has, for the past several months, been in a state of suspension – pending the hiring

of a new Director for that office. DMH officials inform the Court Monitor that a new Director has been selected and will begin her duties in July 2003. The indication is that this new Director will bring considerable vision, energy and insight to this key role. The DMH has made a decision that the newly structured OCFA will be the central point of management of the new consumer grievance rule (discussed in Section III. A. 8. below). The organizational intent is to put in maximum emphasis on consumer and family perspective in the implementation and integrity of the grievance system and peer advocacy program. This is viewed by the Court Monitor as an important and positive decision and is consistent with the clear intent of the Court-ordered Plan.

The DMH Director has also signaled her intent to place the oversight of the consumer satisfaction initiative within the OCFA. While the actual "doing" of the consumer satisfaction would be contracted out, the central DMH accountability would be with OCFA. This is another strong signal of emphasis that the consumers "voice" should be heard in an unfiltered way and that DMH policy and practice needs to be directly shaped by consumers' opinions and needs.

It is evident that the new OCFA Director will have an active year ahead. The Court Monitor will be anxious to track these major developments against the larger goal of creating a true consumer-driven mental health system.

7. **Organizational Development and Training**

The Court-ordered Plan requires a focused effort on organizational and workforce development. Specifically, the Plan calls for the establishment of a Training Institute designed to be the focal point for DMH workforce training and retraining as well as being a vehicle for continuous learning for consumers, community partners and staff of contracted providers.

Beginning in August 2001, the DMH developed and implemented a DMH Training Institute, with the fall 2001 training focused on the array of issues critical to staff and others in complementing the new MHRS services. DMH staff and outside consultants were involved as "faculty" for the training and provided training to over 2300 participants at 11 sites. Since that time, the Training Institute has designed and implemented a number of additional training efforts, including a 10-session Consumer Peer Education Series for 22 consumers who, when completed, received a DMH certificate. The Institute provided another major training effort in the fall of

2002, with over 2000 individuals attending one or more of the 96 different training sessions. The Institute has also developed specific and targeted training efforts in many areas including, for example, cultural competency, consumer choice, provider education from the consumer's perspective, and specialized training for staff and operators of Community Residential Facilities (CRF's).

Upcoming training initiatives include another major MHRS training series for the spring of 2003, coordination of HIPAA training for DMH staff, and specific cultural competency training in the area of gender-identity issues.

It is apparent that the Training Institute has developed as a dynamic model designed to meet an array of training needs. The Court Monitor is pleased to see the ongoing (and growing) set of training offerings.

Beyond the Training Institute, the DMH has approached the organizational development needs on multiple fronts. These include: significant work with local universities as regards the psychiatry residency program; the creation of a new change management program within DMH; and the development of significant "hands-on" technical assistance to CSA's via a DMH contract with the National Council of Behavioral Healthcare (as referenced in the Jan. 2003 report to the Court).

The larger developmental challenges of workforce development remain. It will be critical to develop the capacity within the system to identify individual staff learning/development needs that can then be aggregated so as to help inform the Training Institute (and other training efforts) on priorities. One of the perceived gaps is the lack of Union involvement in the planning of the Training Institute. The issues of retraining and redevelopment will continue; hence, Union participation is still considered an important collaborative effort. Among the vast array of training needs, the Court Monitor would also encourage a focused training effort on front line supervisors and managers as a targeted way of building hands-on understanding of and consistent reinforcement of the new clinical practice philosophy and standards. Another issue of community concern that was raised to the Court Monitor is the loss of DMH training of police officers – something which has in the past been done very successfully by DMH.

Overall, the Court Monitor is encouraged by the evolving training efforts, but clearly the major challenges for learning and practicing in a consistent consumer-driven model remain.

8. **Enforcement of Consumer Rights**

After a lengthy process of review and comment to proposed rules, the DMH has finalized its new rules on Consumer Grievance Procedures. These final rules will be effective upon publication in the DC Register. The new grievance rules set forth a comprehensive approach to consumer rights and protections. Among the key elements are the following: 1.) The requirement that each mental health provider establish (within 180 days of the effective date of the rule) its own written consumer rights policy, which DMH must then approve in order for the provider to be certified or licensed. 2.) The mandate for DMH to provide funding support to establish one or more peer advocacy programs that are independent of all mental health providers. The peer advocacy program would assist consumers throughout the grievance process. 3.) the establishment of clear procedures for the filing of a grievance, consumer protection during the process, and timeframes and due process requirements. 4.) the mandate for DMH to review grievances that are not resolved to the consumer's satisfaction and, 5.) The mandate for DMH to periodically review the Consumer Rights Policy implementation and make public a semi-annual report to summarize the types and dispositions of all grievances.

The Court Monitor finds that these new rules are highly consistent with the mandates of the Court-ordered Plan for enforcement of consumer rights. As noted earlier, the overall management of this function will reside in the Office of Consumer and Family Affairs (OCFA). The DMH, through OCFA, will undoubtedly need some time to assess the adequacy and efficacy of this new rule and how it in fact works at the consumer level. It would seem advisable for the Court Monitor to revisit this issue in succeeding reports to the Court to monitor progress, review DMH semi-annual reports, and gain input from the peer advocacy program(s) that are put in place.

B. *Monitoring of Key Leadership Roles Within the DMH Authority*

1. **DMH Director**

The DMH Director was hired in April 2001, and began her duties on April 23, 2001. The assumption of DMH operational control occurred pursuant to the terms of the original establishment of the Transitional Receivership, which anticipated that a probationary

period would be in place during the Transitional Receivership period. This probationary period began on May 21, 2001. As it occurred, the Federal Court's approval of the Court-ordered Plan, the District Council's approval of emergency enabling legislation to establish the new Department of Mental Health and the appointment of its first Director all occurred in April 2001. Pursuant to Court approval of the May 23, 2002 Consent Order, the Transitional Receivership ended on May 15, 2002. Hence, the new DMH Director has now finished two years as head of this new agency, with the major challenge of creating the necessary structures, hiring key staff and putting multiple systems into place at the same time. The DMH Director has also had the critical challenge of functioning as a new cabinet member for the Mayor — with all of the interagency expectations, cabinet meetings and high visibility problems that go with being a cabinet member. The events of September 11, 2001 took the enormous hill to climb for the new DMH Director and made it that much steeper. The DMH had to gear up in short order to handle the thousands of phone calls, service expectations and community needs for mental health education that grew out of September 11th.

Hence, one can only assess the DMH Director's role and performance in the light of an incredible set of internal and external challenges. By all accounts, the DMH Director has risen to that challenge - bringing enormous energy, knowledge and implementation skill to the tasks at hand. Key leadership positions have been filled — in the main — with competent professionals who have worked very hard to develop and implement needed systems. The primary criticisms of the new DMH have, ironically, been about trying to do too much in too short a period of time. The DMH Director readily admits this is a systems issue, but also asks, "what is it that we can stop doing given the lack of basic infrastructure?" The Monitor's overall assessment is that this is an inevitably high-intensity but unavoidable stage in the overall development of DMH. Clear and consistent communication as to priorities can certainly help, as will growing the breadth and depth of the agency's senior staff so that appropriate decisions can increasingly be delegated below the level of the Director. The planned filling of the Senior Deputy position should help.

2. Chief Financial Officer (CFO)

The Court-ordered plan and the enabling legislation that created DMH were consistent in creating an authority model for the CFO position that attempted to balance the legal requirement that the CFO position to be under the supervisory direction of the District's

CFO, and the desire to have the CFO working as a key part of the DMH's leadership team. There was recognized and inherent tension in this model.

Overall, the CFO position is working as envisioned. The major issues have been turnover in the position coupled with the enormous pent-up pressures to put basic financial systems into place. While the DMH has been forced to use an interim CFO for most of the last year, the good news is that this interim CFO was successful — along with others — in restarting the billings for St. Elizabeths (these billings had been suspended in 2001 due to lack of thorough documentation). The interim CFO was also successful in obtaining a "clean" audit for FY 2002 — a major accomplishment — and in putting basic financial information systems in place to support budgeting and internal financial controls.

Major challenges remain in the overall financial management arena, namely: developing claims processing capacity for the Public CSA (to be discussed separately); reducing the payment cycle for MHRS payments through enhanced electronic interface; developing meaningful and timely internal reports for management as to – e.g., year-to-date expenditures, various reports, productivity reports, etc.; and creating centralized and timely external reporting capacity to the office of the District's CFO and others on issues such as Medicare/Medicaid collections, grants, etc.

The District's CFO — with DMH concurrence — has recently hired on a new DMH CFO. The underlying dual reporting model has inherent problems, but given the current legal structure, these are inescapable. The Monitor's belief is that this model can work if the District CFO and the DMH Director are in agreement on underlying goals and priorities. To date, this appears to be the case. It will be key for the Court Monitor in future periods to track the progress of these key financial systems and the ability of the DMH CFO position to provide needed leadership.

3. **Chief Information Officer (CIO)**

DMH has throughout the past two years employed a Chief Information Officer. Due to position requirements imposed by the District's Office of Chief Technology Officer (OCTO), the current DMH incumbent has moved to a different role within DMH, leaving this key leadership position vacant at this time. Despite this recent development, it is fair to say that the Information Technology systems have taken major strides over the past two

years. Among the major accomplishments of this office are: 1.) Implementation of the DMH enrollment and claims management system. This request for proposal was done in four months and installation in ten months. The application of this component is the basic electronic means by which the DMH has handled the new MHRS community-based system — including managing enrollment, eligibility determination, claims submission and adjudication, and supporting documentation for DMH billing to community agencies. 2.) Support for the DMH Access Help Line. The telecommunications support has provided real time statistics on number of calls, call profile, wait time and calls abandoned. 3.) Office Automation. The Management Information Systems Branch (MISB) has installed computers for almost 900 new users throughout DMH since early 2001. 4.) Development of RFP for the procurement of the electronic practice management system for the Public CSA. This new and comprehensive application will support the required tools for the Public CSA to manage consumer eligibility, clinical documentation, scheduling, records management, claims submission and accounts receivable management. This system is scheduled to be completed in August 2003. 5.) Assumption of direct responsibility for Information Technology and Billing Systems. Historically, the Commission on Mental Health contracted out — at large expense — for its St.. Elizabeths computer system. This included 70 staff being paid for on a contract basis. By creating the necessary in-house leadership and capacity, the DMH anticipates that the total FTE's in Information Systems for 2003 will be 33, with only five (5) of these being on a contract basis.

Despite the major movement in Information Technology, major initiatives remain for the next few years. These include: the need to create mobile technology for staff in out of office settings; the development of a new and significantly upgraded information system at St. Elizabeths Hospital — with needed capitol investment for OCTO to accomplish this; upgrades and enhancements to the existing DMH enrollment and claims management system — to provide more timely payments to providers and less staff rework at both the Authority and provider level; and the full implementation of the Practice Management Information System for the Public CSA — to allow basic business practices to be put in place.

It is encouraging to note that the DMH was successful in getting a #2 ranking in overall District priorities for new I.S. projects for FY 2004.

4. **Government Relations**

The DMH does not employ a fulltime governmental affairs person; rather these functions are shared among the DMH Director, Public Affairs Director, the DMH General Counsel, the DMH Chief of Staff and the Office of Accountability — with the Public Affairs office serving generally as the point of contact. The DMH has established effective working relationships with key governmental agencies in the District — most notably the Mayor's Office and the D.C. Council. Efforts have generally been both responsive (as issues and questions arise) and proactive in terms of informing key mayoral staff and D.C. Council members about necessary legislation and regulations to carry out the mandates of the new Department.

Most of the major legislative goals have been met through the combined efforts of DMH staff and the Mayor's personal support. These include: 1.) the passage of the "Mental Health Service Delivery Reform Act of 2001," which was passed on an emergency basis in April 2001 and became permanently effective December 18, 2001. This is the law that established the new Department of Mental Health and its basic powers and duties in comportment with the Court-ordered Plan; and 2.) the D.C. Council approval of the "Mental Health Civil Commitment Act of 2002," which was passed initially by the D.C. Council on December 17, 2002, and became permanent on April 4, 2003. This Civil Commitment Act reforms and modernizes many of the elements of the involuntary commitment laws that were written in 1964. Most significant are changes to require more frequent reviews for persons involuntarily committed and provisions that allow for acute care psychiatric admissions into community hospitals. These changes are consistent with the mandatory reforms as outlined in the Court-ordered Plan.

Even though the Ervin Act was passed by the District Council in December 2002, it still must be passed by Congress. Due to the provisions of the Home Rule Act, all of the provisions in the Ervin Act that "affect" the Commission on Mental Health cannot go into effect without affirmative action by Congress. These provisions are multiple and go to the heart of the Court-ordered Plans and the DMH's efforts to modernize the civil commitment laws. Unfortunately, there has not been any movement by the District to get Congress to take necessary legislative action. Apparently this issue has gotten "lost in the shuffle"; recent inquiries by the Court Monitor as to status have prompted renewed activity to develop a legislative strategy. Given the high level of importance of the

Ervin Act, the Court Monitor will track this issue carefully and request the DMH and the District to provide timely updates as to progress.

5. **Public Relations**

The DMH does employ a fulltime Public Affairs Director, and has throughout the past two years. The DMH's public affairs efforts were immediately galvanized with the events of September 11, 2001. In very short order, the new DMH became the public focal point for the community's expressed mental health needs. The message — using the DMH Access Help Line phone number — was simple and straightforward: "help is here, right now, when you need it, where you need it." In fact, thousands of District residents did call and the DMH Director became the visible media presence on mental health issues post 9/11. The anthrax and sniper episodes only served to reinforce both the importance of emergency mental health access and the visible presence of the DMH as a vehicle to get information, reassurance, and direct services as needed.

The Public Affairs office is attempting to develop a stronger community relations focus. Efforts have included targeted outreach to various Advisory Neighborhood Commissions and community meetings regarding plans for the new St. Elizabeth Hospital buildings. The DMH is planning to establish a speakers bureau utilizing DMH employees as the "face" to the community. The DMH publishes a regular newsletter to help inform both internally and externally.

The Public Affairs Director is in the process of developing a revised communications strategy; she is doing key informant interviews to help inform as to needs, priorities, audiences and communication resources. The overall goal is to create consistent messages that reflect the Department's shared mission, vision and values. The strategic communication efforts are particularly vital to this department given the decades of organizational inertia, the current pace of DMH change and the continued misperceptions about mental health among the public.

6. **General Counsel**

The Office of the General Counsel within DMH has had a visible and critical presence throughout the past two years. This position — from an authority standpoint — is appointed by the DMH Director but with the approval of the District Corporation Counsel. The original General Counsel recently left the employment of

DMH; there is currently an interim General Counsel in place. It is unclear how quickly this position will be filled on a permanent basis.

It would appear that the general role and functioning of the General Counsel — as articulated in the Court-ordered Plan - is working. The General Counsel has functioned as the Department's principal legal advisor on all issues as they relate to its Authority functions. The General Counsel position does function as a member of the DMH Director's Senior Executive Team and this position has been instrumental in the negotiating and drafting of key legislation — most notably the changes to the Ervin Act. The General Counsel is heavily involved in several areas including the drafting and promulgation of DMH rules, the review of policies for providers seeking certification, and the overall development and legal sufficiency of DMH policies and practice in key areas, e.g., the requirements of the Health Information Portability and Accountability Act (HIPAA).

The General Counsel for DMH has also taken on a legal leadership role in matters related to Dixon. This allows for full and open discussions with the Court Monitor on the multiple issues at hand.

The overall role and functioning of the General Counsel position is seen as consistent with the Court-ordered Plan. The immediate concern is that the current interim General Counsel is attempting to wear the multiple hats of General Counsel, Deputy General Counsel and the DMH Labor Attorney. It will be critical for the District to fill the General Counsel position as soon as possible so that a full complement of attorneys can assist the DMH in its oversight role.

7. **Compliance Officer**

The DMH has employed a fulltime compliance officer for most of the past two years. This position became vacant in March 2003, when the incumbent relocated. The position has been refilled with the new compliance officer beginning in the very near future.

The focus of the compliance officer has been in two primary areas: establish and maintain an overall compliance program for the DMH and attempt to remediate past billing issues with the Federal government (CMS) for Medicare/Medicaid. As to the overall compliance program, the compliance officer has taken the lead in crafting an overall compliance plan for DMH. The plan has been formally approved and represents a reasonably comprehensive

approach to the compliance needs of the DMH. The compliance officer — as a separate document — has also developed a code-of-conduct policy for DMH staff. This policy is currently waiting for final approval from the office of Corporation Counsel. As part of the ongoing compliance plan, the compliance officer has worked collaboratively with the Office of Accountability to create an overall auditing protocol for claims submitted by DMH providers. This auditing protocol is in the early stages of implementation, but thus far is accomplishing the goal of creating varying levels of auditing oversight for providers — dependent upon demonstrated performance.

Progress has been made toward resolution of issues regarding past billings to CMS - with recent agreement having been reached with CMS on a valid approach to reconciling claims for prior periods. This issue has consumed considerable portions of the compliance officer's time; hence, it is significant and critical that issues that predate this new department be resolved as expeditiously as possible so that the entire focus can be on current and future compliance efforts.

In general, the compliance officer role has evolved as the Court-ordered Plan contemplated. An overall policy and practice framework has been put in place. However, the actual implementation of a viable compliance program at the provider level (and oversight of same) is still largely to be accomplished. It is noteworthy – as part of an overall compliance effort – that the DMH has recently hired an Internal Auditor. This new position will initially focus on the financial requirements of the MHRS Standards and the degree to which CSA's are in compliance. The position is intended, however, to function as a true internal auditor – with the ability to review a range of practices, programs or reported irregularities within the agency. This should add to the DMH's overall compliance capacity. The DMH corporate compliance officer role will also be stretched by the recent addition of HIPAA compliance requirements. It is critical that the DMH continue to support this key office so as to provide leadership on the full development and implementation of a compliance program.

8. **Clinical Officer**

The DMH has employed a fulltime Board certified psychiatrist as the Chief Clinical Officer (CCO) for the past two years. This position reports to the DMH Director and provides leadership and oversight on clinical and medical policies, rules and practices

within the Department. The CCO works as an integral part of the senior leadership team. Specific policies over which the CCO has leadership responsibilities in development and implementation include: treatment planning; seclusion and restraint; incident reporting; and medication administration. In addition to the routine duties of the position, the CCO has also taken on a leadership role in the following areas: a) Implementation of DC-MAP, which is an algorithm-based set of best practice guidelines for the administration of psychiatric medications for schizophrenia and clinical depression, b) Implementation of an agreement with Children's National Medical Center to provide emergency site-based psychiatric services for all children and youth in the District, c) Functioning as Medical Director and contract officer for the Federal mental health grants for disaster and emergency response post September 11th and the anthrax and sniper episodes, d) Working as part of a core team at DMH to train and implement best practices for persons with co-occurring illnesses (mental health and substance abuse), e) Working with local acute care hospitals to admit involuntary patients, f) Development of a system to monitor and track the required periodic review of the over 400 civilly committed patients to determine the need for continued commitment, g) Provision of leadership in the revamping of the psychiatry residency program, h) Provision of clinical leadership in the development of clinical practice guidelines for referrals to specific therapies, and i) The introduction of LOCUS – a national model to assist in level-of-care decisions.

Overall, the Chief Clinical Officer role has evolved as envisioned in the original Court-ordered Plan. The successful development and oversight of acute care contracts with local hospitals and the oversight of the new requirements of the amended Ervin Act are among the multiple challenges that remain for the CCO and the Department overall. It is also vital that the CCO develop the capacity to measure actual compliance with D.C. MAP. While the provisions of D.C. MAP are mandatory, it is very uncertain as to the degree of actual compliance among providers.

C. Maximizing Federal Revenue

The Court-ordered Plan was clear that the DMH needed to develop both the clinical infrastructure (via MRO) and the administrative capacity to maximize Federal revenue. The reasons for this are straightforward; a significant percentage of mental health consumers are Medicaid eligible, the MRO services are Medicaid eligible and the Federal portion of Medicaid payment in the District is high (70%). Hence, for every Medicaid-eligible service

dollar delivered, it would take only 30 cents of local match funds.

The question for this report is how is the DMH doing in this overall effort to maximize Federal revenue. The results to date are mixed. From the standpoint of enrolling providers and providers enrolling clients, the growth line has been consistently (and at times dramatically) upward. The question of maximization has more to do with the issues of productivity (are agencies "producing" revenue at the expected rate?) and processing (are claims being authorized, processed and paid in an expeditious manner?).

In terms of the timely processing of claims, it is probably fair to say there has been improvement from the time of the first Report to the Court, but that considerable additional improvement is needed. Several of the major barriers are being addressed. One involves a programming change to the eCura system so as to unbundle the authorization plans from the ability to process claims. DMH reports that this change has been made and will help to speed up claims payments. Another major eCura problem is that the current system requires that CSA's "roll up" services onto one claim if more than one allowable service is provided on the same day. This issue has created a major backlog in accounts receivable for some CSA's (one CSA alone has receivables of $1.8 million over 60 days old largely – apparently – as a result of this issue). DMH staff are well aware of this problem and are having to manually override the eCura system to correct the problem.

The second system problem is the way in which provider agreements are constructed. At this point, each separate service area (of the nine MHRS services) constitutes a separate "contract," so payments begin to kick out once limits for the year are reached. The DMH intends in 2004 to bundle all of these so-called "Task Orders" into one contract as a way to simplify and expedite. Despite all of these ongoing issues in approval and processing of claims, it nevertheless appears that the DMH will meet its budgeted Medicaid targets for 2003. What is not clear to the Monitor is how close to maximization of Federal revenue this $17.5 million is coming. Further analysis will be required to answer this question.

The issue of productivity exists at several levels – at the macro DMH level and at the individual agency level. It is clear that all providers are having to look at staff productivity in careful ways in order to survive in a fee-for-service world. The major issue for DMH – in terms of budget projections for 2003 – has to do with

the Public CSA. The DMH projected in its 2003 Budget Federal Medicaid revenue of $21 million for the Public CSA (although internal estimates with the Public Core were set at $16 million); in reality the number will be closer to $11 million. As noted in Section III D 4, there are unique and major barriers for the Public CSA. Among these, undoubtedly, are issues of staff productivity and the agency's ability to both measure and monitor productivity without an electronic information system. It is clear that the DMH – through the Public CSA – will need to make quantum leaps forward if it is to achieve the 2004 Budget targets of $24.9 million for the Public CSA.

D. Review of DMH's Role as a Provider

The Court-ordered Plan came to the conclusion that the new DMH had no choice – at least for now – but to be a major direct service provider for specific mental health services through St. Elizabeths Hospital and a consolidated single-entity CSA. This conclusion was largely based on the reality that there were not viable alternatives (including capacity) to contract through the private sector to meet the array of needs. The overall thought was that the CSA system needed time to develop and stabilize before any longer-term decisions regarding the DMH's role as a CSA could be made. As it relates to St. Elizabeths, the Court-ordered Plan clearly envisioned that the hospital would increasingly function as a tertiary care hospital on the civil side, with the new CSA system being primary and local acute hospitals being secondary for persons needing acute hospitalization.

For both St. Elizabeths and the publicly-run CSA, the Plan envisioned a model that would maximize the degree to which these entities would have clear accountability and delegated authority to perform in this new system.

The purpose of this review by the Court Monitor is to see what progress (or obstacles) exist in carrying out the basic tenets of the Court-ordered Plan.

1. Management and Role of St. Elizabeths Hospital

   St. Elizabeths continues to provide multiple hospital functions for the District, including its traditional role as a forensic hospital. All clinical and administrative services have been consolidated into the east campus, which has provided a considerable increase in efficiencies and cost savings. St. Elizabeths is the primary point of admission for

acute care in the District for adults who are involuntary or who do not have a source of payment. Inpatient admissions continue to run at a high level, with approximately 1,400 admissions per year. As a result of this high volume of admissions, St. Elizabeths has designated approximately 50 acute beds and an additional 50 acute step down beds.

St. Elizabeths, through its Director, has made significant progress on several fronts. The most notable program development has been the implementation of the Treatment Mall concept. Under this model, which has now been in place for over a year, civil side patients have an individualized schedule for each day – with "classes," skill-building and therapeutic events, which they receive in a physical location, separate from the sleeping units. Ward staff and professional staff also participate as teachers or facilitators. This Treatment Mall model – which has been used successfully across the country – has had demonstrable effects. The most recent Federal site visit (by CSM) indicated that there are record documentation issues, but did not question at all that patients were receiving "active treatment." This is in sharp contrast to earlier Federal visits, which underscored the number of patients sitting on wards without an apparent treatment or activities program. The Treatment Mall is also credited with the sharp reduction in the use of seclusion and restraint for patients and (though not documented) the decline in PRN (emergency) medication normally used when patients are agitated or out of control. The Court Monitor observed the Treatment Mall concept in action and was impressed with both staff and patient participation. Staff are continuing to refine and develop the Mall concept.

Despite the above, there are many continued barriers to the effectiveness of the hospital. These include: 1.) Census levels in the past eight months have fluctuated from 490 to 540, with over 100 of these beds dealing with acute care. Acute beds require more staff and put additional pressure on overall budget constraints. 2.) The recruitment and retention of key professional positions remains a problem – most notably physicians and nurses. At the time of this report, for example, there were eight physician vacancies (six psychiatrists and two general medical officers). It is hoped that the planned increase in psychiatric base pay will help, but it is too early to see discernible evidence. 3.) The hospital is largely dependent upon the DMH authority for key

supports – particularly in areas of finance, human resources, and information technology. While this is not inherently bad, it does create issues of who makes which decisions and has authority over what. The DMH Authority, together with the leadership at St. Elizabeths, are actively working to build the needed (and appropriate) support positions at all levels (e.g., the recent hiring of a finance director at St. Elizabeths). 4.) The hospital – while now on one campus – continues to operate in buildings that are largely antiquated. Progress on the new hospital will be discussed below, but it is a continued reality that patients and staff are living and working in buildings that are not at all suited for quality patient care. Not only is this difficult for quality patient care, it also uses budgetary resources to keep the physical plan working. For example, the DMH had to spend $2.7 million this past winder to repair broken water mains. 5.) The Treatment Mall – by all accounts – has made a large impact on overall patient care. However, the Mall operates exclusively during the first shift. The second and third shifts continue to suffer from staff vacancies and the traditional challenges of feeling "left out" in terms of treatment team inclusion. Now that the agency restructuring is over, it is hoped that staff vacancies that are approved can be filled as expeditiously as possible. 6.) The DMH has an official rule on continuity of care which requires CSA's to visit assigned patients who have admitted to St. Elizabeths and work as an active part of the treatment and discharge process. It is not clear that this policy is fully working. The ultimate impact on St. Elizabeths is longer lengths of stay, which in time exacerbates staffing and budgeting concerns. The Court Monitor will, in future reports, seek to understand more fully the status of this policy and its current level of compliance.

2. Planning for New/Consolidated Hospital

The DMH and other relevant District agencies have spent considerable time and energy in planning for a new/consolidated hospital. At the time of this report, the basic architectural, site selection and space programming functions are complete. The basic plan is to build an entirely new forensic facility and a mostly new civil side facility; some civil side units will be rehabilitated to allow for potential capacity demands. One of the exciting space planning concepts in both the forensics and civil units is to create the ability for patients to access outdoor space on an

as-desired basis. The key to this concept working is having secured perimeter space – especially for forensic patients.

The DMH has encountered numerous unanticipated hurdles in this planning process. The major ones are: 1.) the need to obtain zoning approval and other governmental approvals. This has slowed down the process and meant endless hours in meetings and hearings for the DMH Director and others. 2.) the original funding for the new hospital (1998) did not include the costs of infrastructure development (e.g., running of new utility lines) and did not conceive of treatment and living units that require a larger footprint in order to achieve outdoor access. Also, the passage of time (5 years) has added inflationary costs to the original request. The net effect of all these factors is that the current available funding for the new hospital buildings is significantly short of what will be required. The Court Monitor has been informed that District officials are nonetheless committed to moving forward with building plans and will seek from Congress the additional funds necessary. The best estimates, in terms of timeframes, is that construction will begin in 2004, with occupancy in 2006. The current construction model calls for a total of 292 newly constructed beds, to include approximately 178 forensic and 114 civil. The rehabilitation of existing buildings, however, will provide additional capacity – if needed – in excess of 500 total beds.

3. Development and Utilization of Acute Care Contracts with Local Hospitals

The DMH has had for some time referral agreements with two local hospitals that provide acute care for children and youth. These agreements have been critical since the DMH does not provide any acute care for children/youth at St. Elizabeths and does not plan to provide such capacity in the new hospital. Although there are ongoing issues as relates to the quality, performance, and accessibility of these local hospitals, the general assessment is that this referral model is working. It is the DMH's (and the Monitor's) hope that the legal and logistical impediments to using Children's Hospital will be removed. This will be discussed in Section IV D of this report.

On the adult side, progress in negotiating viable agreements with local hospitals has been much more limited. DMH does have a signed referral agreement (no dollars) with Greater

Southeast. This agreement (signed in early February 2003) – provides for voluntary admissions and also involuntaries admitted under the Ervin Act. Greater Southeast does have a 20-bed adult unit. DMH staff indicate that it is too early to say what volume this agreement will generate. There are several financially complicating factors – namely the current bankruptcy status of Greater Southeast and the fact that the Medicaid professional services rates are highly unattractive and will make it difficult for this hospital to attract willing psychiatrists.

There is indication that at least one other local acute care hospital has interest in developing or expanding its adult acute bed capacity and would (if this expansion occurs) be willing to accept involuntary patients. It will be at least fall of 2003 before this would occur if it does happen.

The Court Monitor is very concerned about the pace of negotiating acute care agreements or contracts. The Court-ordered Plan clearly anticipated that the new hospital (or rehabilitated existing units) would only be a focus for acute care if all local options had been exhausted. The same concerns that were spelled out in the Plan continue to exist – the major ones being the lack of Medicaid reimbursement for ages 22-65 due to St. Elizabeths IMD status and the stigmatization associated with a state hospital admission. The DMH under the current arrangement is incurring the full expense (with very limited reimbursement) for the approximately 70% Medicaid eligible population that is getting acute care at St. Elizabeths. This is not an acceptable going forward solution. The Court Monitor recognizes that these are difficult and often complex agreements to negotiate and that local hospitals must be willing and able to contract for such services. Also requiring a solution is the financing of indigent (and non-Medicaid eligible) acute care patients – both voluntary and involuntary. The current formula in the District for apportioning Disproportionate Share revenue should be part of the overall solution.

4. Management and Role of DMH-Operated CSA

The DMH runs a so-called "Public Core" (CSA) which is far and away the largest CSA in the system. The Public CSA has enrolled over 7,000 consumers, some 55-60% of the total persons in the CSA system. The process of bringing this CSA into full compliance and attaining operational

effectiveness has been a mammoth undertaking. Under the leadership of a strong CSA Director, this entity has made significant progress in the past year in many areas including: 1.) ensuring the accuracy and timeliness of clinical records for billing purposes, 2.) creating a basic management and clinical team structure, 3.) expanding evening and weekend hours to accommodate consumer needs, 4.) reorganizing medical clinics and pharmacy services, 5.) participating as a key player in the DMH initiative on co-occurring disorders, 6.) managing the upheaval associated with the reductions-in-force (RIFS) that occurred as part of the overall agency restructuring (see Section V E discussion of DMH restructuring). These achievements are considerable in light of a history for DMH-run services that has had limited focus on documentation or staff accountability and that historically functioned only as the outpatient "clinic" arm of a hospital-based system. The change in role to a community-based system is enormous and needs to be appreciated in evaluating the obstacles that remain.

Nonetheless, there are major issues that remain to be solved. Perhaps the major one is the fact that the Public CSA has not – throughout this period – had an automated information system. This has been a major obstacle in being able to submit claims, measure productivity and track individual, team and overall performance. It is also a fact that – due to multiple billing and quality requirements – there were major delays in processing claims. The DMH is in the process of changing eCura software so that the authorization process will not impede claims processing. It is also planned that the requisite information technology system will be in place by October 2003. It is unclear to the Court Monitor how much of the back billing for the Public CSA can be recouped.

Going forward, once the information technology systems are in place and the authorization issues are fixed, it is still uncertain as to the degree which the Public CSA can support its cost structure with earned MHRS (and other) revenue. At the current rate, the Public CSA will produce $11 million of billable services for FY 2003. This compares to a cost structure for these same elements of $30.4 million. This major subsidy to the Public CSA raises serious concerns about the longer-term viability of this model. Even the ambitious 2004 goal of billing $24.9 million in MHRS services for the public CSA would still leave approximately a $6 million "subsidy."

A superficial analysis of the fundamental elements of the cost structure versus the revenue capacity suggests that there are major impediments to getting to a breakeven point. The potentially manageable ones include getting to staff productivity levels that are sustainable and maintaining the requisite levels of quality control in terms of timely and accurate charting. The new information technology system will also provide the ability to bill payors other than Medicaid and accept co-pays – none of which is happening currently. The even-more-difficult to overcome issues, however, go to salary structures for staff (which are generally higher than the marketplace), the inflexibility of the personnel system in dealing with employee non-performance, and the residual of high fixed costs in terms of buildings and overhead.

The Court Monitor does not, at this point, wish to make any final judgments about the viability of the current Public CSA model. Clearly it is a work in progress and the positive steps underway need to be encouraged and continued. It is also likely that there are other less-visible subsidies in the old contract system, e.g., residential service contracts. However, as DMH approaches the one year mark for the Public Core and the two year mark since the passage of the Mental Health Reform Act, it would seem that now is the time to begin looking at the question of the longer-term service role, structure, governance, and the underlying business model for the current Public CSA. In the meantime, it would seem appropriate that the DMH, as an authority, articulate clear performance-based expectations of the Public Core CEO and delegate maximal authority to this entity "as if" it were a contracted provider.

It is unclear to the Court Monitor – as with St. Elizabeths – where the boundaries exist in terms of roles, decision-making, accountability and authority in today's reality between the authority and the two DMH provider CEO's. While some of this is undoubtedly developmental and due to the unique role and history of both entities, it does appear to the Court Monitor that continued work – which has already begun – to clarify roles, decision-making, etc., is needed. The recent inclusion of the Public CSA CEO and the St. Elizabeths CEO in bi-weekly decision-making meetings should help to strengthen lines of communication and clarify relative roles.

E. Review of Role and Functioning of the Partnership Council

The Court-ordered Plan called for the establishment of a 15-25 member Partnership Council which would serve as an "active advisory body" to the DMH Director – meeting regularly to provide advice on key policy issues such as the DMH budget, strategic plan, and major program initiatives or policy changes. The Partnership Council has been composed and meeting on a monthly basis since the middle of 2001. Its composition does reflect a majority of consumer (primary and secondary) members and its overall membership is diverse and broadly representative. As a functioning group, however, the Council has struggled to achieve a clear sense of its role and purpose. Across the range of DMH initiatives and changes, the Partnership Council members have not had a clear sense of "when and where and on what" advice was being sought. The encouraging sign is that the Partnership Council recently had a retreat – with an outside facilitator – which served as a very productive time to discuss mutual roles and expectations between the DMH Director and the Council. Concretely, it was decided – in the months ahead – to sharpen the priority focus of the Council on the issues of the DMH budget and the strategic plan. The Court Monitor is encouraged by these recent developments and is hopeful that the next six months will see positive steps in the role and vitality of the Partnership Council. In the final analysis, the Council needs to, in fact, function as an "active advisory body" – a consistent source of feedback and support to the DMH Director.

F. Review of Integration of Mental Health and Drug and Alcohol Services

The Court-ordered Plan called for the creation of a Mayoral-endorsed initiative to evaluate the need for changes in programs, policies and organizational structures in order to better meet the needs of persons in the District who have co-occurring disorders (serious mental illness and alcohol and other drug abuse). This initiative was considered critical given: the parallel agency structures in the District (DMH and Addiction Prevention and Rehabilitation Agency (APRA)), the growing awareness of the number of persons with co-occurring disorders (with estimates of 20,000 to 42,000 in the District alone), and the clearly demonstrated practice models from across the country on serving this high-risk population.

The District has responded to these needs and opportunities. Beginning in July 2002, DMH and APRA have collaborated on an initiative that is intended to serve individuals with co-occurring disorders in a new way. National experts have been engaged to help

develop and implement these new initiatives. The new model builds on the need for an integrated service response that represents currently established and "evidenced-based" practice in the field. Efforts thus far have focused on leadership and staff training – with some 40 persons having been trained so far, who in turn will train others. This initiative is included, and is clearly the driving new philosophy of care, in a charter and consensus document signed on April 30, 2003 by the Department of Health (for APRA), and the DMH Director and the Mayor. This charter commits both agencies to multiple ongoing systems and services changes to incorporate the new model.

In addition, DMH is collaborating with the D.C. Community Partnership for the Prevention of Homelessness (the "Partnership") on a request for HUD funds targeted specifically for individuals who are homeless and also have co-occurring disorders. The initial target is 85 chronically homeless and dually diagnosed men and women living on the streets or in emergency shelters. This initiative (if funded) intends to subcontract these services, using the successful New York City model Pathways to Housing. DMH intends to seek Federal funds from the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide the necessary high intensity support services for this population. The overall goal of this initiative and its agency partners is to provide an integrated services model that responds to consumer needs for mental health, substance abuse, and health care services, as well as providing immediate access to independent and stable housing.

The Court Monitor is pleased to see the multiple initiatives (including the Sobering Center Project and the Alpha Project) that are underway for this exceedingly high-risk population (persons with co-occurring disorders). It is evident that the Mayor's office is supporting this cross-agency initiative. It is also evident that concerted and sustained efforts by both DMH and APRA will be required to make these new models a reality.

G. Review of 2004 DMH Budget

The DMH 2004 Budget request – and necessary approvals – has been through several stages. At this point, the DMH 2004 Base Budget stands at $194.8 million. In addition, there are two reserve funds in the '04 budget targeted for DMH. There is a $21.7 million reserve for potential Medicaid shortfall and a $2 million reserve to cover court-mandated staff hiring expenses. Hence the total '04 budget (including the reserves) is $218.5 million. It was very evident to the Court Monitor that the Mayor did all that he could to support the DMH budget request as it went through the District Council process. In a

budget year with large financial constraints for the District, it was noteworthy that the DMH budget received priority attention.

In addition to the operating budget, the DMH has also gotten significant support in the '04 budget for capital – with over $25 million targeted for major projects to include $10.9 million for renovations and repairs at St. Elizabeths, $5.5 million for supported housing, $8 million for renovations of the North Center and $1.3 million for the purchase and installation of a new information system at St. Elizabeths. This is a major accomplishment, given the overall reduction in the capital budget for the District.

Nevertheless, there are significant concerns heading toward the 2004 budget year. Some of the major ones have been discussed in this Report, namely: the ability of St. Elizabeths to reduce beds by way of effectuating acute care agreements; the ability of the Public CSA to meet productivity and revenue targets of $24.9 million for Medicaid; the ability of DMH to forecast contracted CSA volume by agency and in the aggregate; and the ability of DMH to program dollars into appropriate cost centers in line with actual expenditures. As noted, the 2004 Budget for DMH places $21.7 million of its overall budget in a Medicaid Reserve Fund, and $2 million in a separate Reserve. It is not entirely clear to the Court Monitor what the constraints will be for the DMH to access this "revenue". It is clear, however, that given current service levels and required Court mandates, it will be absolutely critical for the DMH to have full access to the $23.7 million reserved dollars. The Court Monitor will need to stay closely attuned to this situation as the budget moves through Congress and into reality.

IV. Review of Continued Development in Key Systemic Areas

The January 13, 2003 Report to the Court detailed systems progress and barriers in key systemic areas that directly impact the overall ability of consumers to live, work, develop and recover in the community. This Report – and future reports to the Court – will continue to track progress in these key areas.

A. Housing Capability

DMH continues to play a leadership role in the multiple interagency efforts that are designed to increase the overall numbers as well as the diversity of affordable housing available to persons with a serious mental illness. In a broad sense, all of the initiatives grow out of the April 2002 report from the Corporation for Supporting Housing (CSH). The recommendations from CSH

were intended to create an interagency initiative designed to increase the leveraging of DMH capital dollars and strengthen partnership between DMH and other housing-related entities in District government. Continued housing efforts toward the creation of new capacity include the following:

- The finalization of the 2003/2004 Housing Business Plan by June 30, 2003. This Plan – with the critical input of D.C. Housing agencies and interested stakeholders – emphasizes the need for additional supportive housing for consumers.

- Negotiations are in process with Fannie Mae's American Communities Fund and the D.C. Partnership Office to establish the first Fannie Mae equity investment in "scattered site" properties available to DMH consumers. Negotiations are intended to be concluded by July 11, 2003. The scattered sites will be properties with one bedroom and efficiency apartments.

- A Joint Venture Agreement with the D.C. Housing Finance Agency (DCHFA) – to be signed by July 1, 2003 – to provide for a $10-$15 million annual set aside of DCHFA bonding authority for DMH-sponsored developers. This financing will provide lower financing costs to developers and thus lower rents for consumers.

- A Joint Venture Agreement with the D.C. Housing (DCHA) is currently planned for signatures by July 30, 2003. This Agreement will provide 200-300 surplus annual contribution contracts for rental subsidies from HUD; these surplus contracts have resulted from the closing out of public housing projects in southeast D.C.

- DMH has been granted set aside usage of four D.C. owned properties that deeded to the District as a result of the owners' failure to pay taxes. DMH will issue an RFP for the development of these properties in July 2003.

- DMH is submitting an application for a five-year grant for $750,000 under the HUD Super NOFA program to provide Shelter Plus Care supports to eligible consumers. The application was submitted May 30, 2003 to the Community Partnership as part of the 2003 Continuum of Care – Homeless Assistance Programs.

DMH estimates that the net result of all these new Housing capacity initiatives should result in supportive housing units for an additional 800 consumers over the nest three to five years.

At the present time, DMH continues to provide housing and residential support as follows: 1.) Approximately 780 DMH consumers receive rental subsidy, with capacity to add 75-100 additional consumers, 2.) 167 Community Residential Facilities (CRF's) are licensed by DMH with total capacity of 1,030 beds, 3.) DMH has awarded $2.0 million in local and Federal funds to the Greater Washington Urban League to provide bridge (temporary) rental subsidies to some 450 consumers.

Overall, the supportive housing initiative appears strong. There continue to be major issues relative to the need to shift resources and options from CRF's to supportive housing. The DMH has begun a process that will "unbundle" residential support services from housing and allow the support services to be billed via MHRS. This will be a major initiative via existing providers, but should have the dual positive impact of saving local dollars and promoting the notion of housing supports as an independent activity from core housing expenses. It is also important, as noted in the first Report to the Court, that DMH develop a database that allows a clear baseline for tracking all of the housing/residential options, as well as persons served at any given point in time. DMH indicates that it is working to create such a system. The Court Monitor will review this effort in the near future.

B. Supported Employment

The first Report to the Court outlined DMH leadership efforts to develop a supported employment program within DMH and the District. Those efforts have continued. Since the time of the January 13, 2003 Report to the Court, the DMH has pursued efforts on several fronts:

- The three demonstration sites have been selected and funded as part of the Johnson & Johnson/Dartmouth evidence-based practice initiative. These small grants have permitted the three agencies to hire employment specialists and begin enrolling clients. In the near future, data will be available at these sites to measure key performance and outcomes (e.g., number of people working in integrated employment, average hourly wage, etc.) While each site has unique issues, it is already apparent that the demand for employment specialists far

exceeds current capacity (e.g., one site already has 200 clients on the waiting list.) DMH is beginning to explore other funding options that would allow for program expansion.

- Beyond the three demonstration sites, DMH is working to provide training and support to other providers in learning and implementing this new model of Individual Placement and Support (IPS). For example, two of the CSA's have redesigned their vocational service efforts to be consistent with the IPS model. Targeted training has been scheduled for the Public CSA staff that are working on ACT Teams; the four vocational staff in ACT will be trained to work as employment specialists.

- The web-based course that was designed in collaboration with Virginia Commonwealth (VCU) has completed its first phase of lessons. The next phase will involve specialized lectures targeted to physicians, case managers and consumers.

- The Public CSA in May 2003 launched a major initiative to shift its sheltered work program to a supported employment model. This is a major initiative, but again reinforces the DMH's commitment to a different model.

Broadly stated, the supported employment initiative continues to move forward. It is evident that the major policy, clinical practice and funding issues that need to be addressed are in fact being addressed to allow this effort to gain real momentum.

At the April 2, 2003 kickoff for the Johnson & Johnson grant, the DMH Director called for the creation of an interagency task force that would be charged with recommending needed systemic changes in order to fully implement evidence-based supported employment in the District. The Court Monitor is encouraged by this step and will continue to track progress.

C. *School-Based Services*

The school-based mental health initiative continues to develop and expand. The DMH has been in 24 different schools (10 charter and 14 D.C. Public) throughout this period. The clinical staffing is almost complete and necessary supervisory positions have been added and are being recruited to provide more direct clinical supervision and oversight.

The Teacher Assistance Teams (TAT) are the main mechanisms in the schools for early identification, triage and referral. This mechanism has gained consistency in most schools and has allowed for greater coordination, better communication between educational and mental health staff and overall improvement in the utilization of school-based mental health clinicians. The volume of referrals reflects this improved communication. For the four-month period of January-April 2003, there were 1,490 children who were served in the schools. Services included a wide array of individual, group and family therapy services, as well as case management and care coordination. It is also encouraging to see the growth in consultations with parents and teachers during this period.

In addition, DMH has recently added five new clinical positions to allow expansion into five new transformational schools and DMH has added one additional charter school. When this expansion occurs, the DMH school-based initiative will be up to 31 schools (11 charter and 20 D.C. Public).

The issue of longer-term fiscal viability for this initiative remains, which should include the active exploration of MHRS eligible funding to cover at least some portion of the costs. The DMH indicates that it is pursuing with key District agencies the potential of a pilot initiative in the upcoming school year to bill MHRS services. It is apparent that the school-based initiative is gaining increased understanding and acceptance and can – with ongoing fiscal and leadership support – continue to grow.

H. Capacity for Children/Youth to Live in Own Home or Surrogate Home

The DMH, through its Child and Youth Services Division (CYSD) has continued to advance its multi-pronged efforts to promote a "systems of care" model in the District. The following represent some of the major initiatives/progress in that regard:

- The Multi-Agency Planning Team (MAPT) continues to assess youth who are at risk of out-of-home and often out-of-District residential placements. These youth – who come from all of the major child-serving agencies in the District – are assessed through one of three broadly-constituted teams. Since the beginning of this effort in November 2002, 235 children/youth have been referred to MAPT. Of the 235, 199 been diverted from residential and 36 have been referred for residential. These numbers are impressive on their face and

represent a continuing strong interagency effort. What is critical is the ability to track what happens to these children/youth – both those diverted and those placed into residential care. The key question is whether these high-risk youth are entered into a care management model that works intensively to provide the array of services necessary to successful community living. It is the Monitor's view – as noted earlier in this Report – that those children/youth placed into residential care should also be enrolled into a CSA so that work with families, communities and residential staff occurs throughout the residential setting. As noted earlier, DMH has begun work on this complex issue.

- The Mental Health Care Subcouncil of the Mayor's Intergovernmental Youth Investment Collaborative has undertaken a strategic planning initiative that is targeted toward building a system of care model. The initial emphasis will be on creating a single portal of entry for the multiple child/youth agencies in the District. This single portal concept could help greatly to maximize Medicaid eligibility, standardize access and care through common providers, and improve overall continuity of care.

- The Alternative Pathways Grant via the Juvenile Justice Advisory Group (JJAG) is being utilized (among other things) to hire front-end screeners to be located at the First District Precinct to help train police officers to identify youth with mental health and/or substance abuse disorders. This grant is also being used to develop protocols for the interagency assessment teams that are organized to help develop a youth diversion process. This assessment process should change and improve the process for evaluations of children/youth who have pending cases in Family Court.

- The DMH has formed an Acute Care Workgroup to develop policies and procedures for linking children/youth and families to a CSA upon their admission to an acute care hospital. There are multiple issues involved in the acute care arena for children/ youth, including issues of timely access, legal status (FD 12's) and the overall utilization of acute care beds. On any given day, there are frequently no acute care beds available for children/youth. On the other hand,

the Acute Care Workgroup has noted the frequent use of acute care beds for placement, pending foster care, and the use of inpatient hospitalizations for 21-day court evaluations. The DMH is hopeful that – through the work of this committee – there can be significant improvement in accessibility, linkage and ongoing CSA involvement for this subset of the high-risk youth population. For example, the DMH indicates that it plans an "Urgent Care" Center at Children's Hospital as one concrete way to expedite assessments and appropriate services access. It is the DMH's intent – following this effort – to create similar capacity as relates to Residential Treatment Centers. The Court Monitor will – with the work of DMH – need to evaluate the need for any additional acute care services, e.g., short term crisis beds for children/youth.

It should be noted in addition to the above, that DMH is cooperating with requests for information from the Washington Post as it relates to historical and current oversight and usage of children's Residential Treatment Centers. Other child caring agencies in the District are in a similar response mode. While it is unclear where this overall issue is headed, it serves to underscore the critical importance of creating and implementing coordinated and accountable interagency care plans for high-risk children/youth. The existing reality is still one of over-reliance on expensive institutional settings.

All in all, it is very encouraging to see the level of leadership efforts in the whole child/youth area. This major effort to build systems of care is now firmly grounded but will take years of high level leadership, infrastructure development and systems reform at all levels. The Court Monitor will continue to track these efforts closely.

V. Follow-up on Previously Identified Areas of Concern

A. Site-Based Psychiatric Emergency Services

The January 13, 2003 Report to the Court detailed the fact that the DMH had developed a contractual agreement with Children's Hospital to do all site-based psychiatric emergency assessments for children/youth (as opposed to CPEP). While volume levels continue to run higher than originally expected, it appears that this arrangement continues to work well overall. The Acute Care Workgroup referenced in Section IV D should provide further assistance to Children's in dealing with the day-to-day issues of available beds, FD

12's, and enrollment and care coordination via the assignment of a CSA.

The major unresolved concern is on the location and limitations of the adult CPEP program for adults. The first Report to the Court recommended that the DMH pursue alternative sites for CPEP, preferably "in a setting that supports medical triage, quick access to medical treatment, and an adequate professional-looking location." To date it is not evident to the Court Monitor that there has been any substantive progress on this issue. While there may well be other emergency models that would meet the community's needs (e.g., increased use of mobile teams), the current site and its inherent limitations are not acceptable.

B. Development of Crisis Residential/Respite Beds

The January 13, 2003 Report to the Court indicated that the lack of any crisis residential beds in the District for adults "is limiting options in the acute care area, thus forcing admissions to inpatient settings that could be avoided or shortened." There was indication at the time of the first Report that funding was available and that contract negotiations were underway with potential providers. Unfortunately, at the time of this second Report, there are still no crisis residential beds available. The DMH Crisis Planning Task Force report of April 4, 2003 underscored the need for intensive crisis beds by pointing out that from October 2002 – January 2003, DMH care coordinators noted on 163 occasions that crisis beds were considered for St. Elizabeths diversion, but were obviously not used due to not being available.

The DMH, to its credit, has again gotten active on this issue and is prepared to issue a Request for Quote (RFQ) in the very near future. The expressed intent of the DMH scope of work is to contract for eight (8) crisis stabilization beds that would be staffed around the clock and be able to handle psychiatric emergencies that do not need inpatient acute care but that do require professional staffing that includes nurses and a consulting psychiatrist. The anticipated rate is $314.00 per day and the one-year contract would be via a Human Services Agreement beginning September 1, 2003 through August 31, 2004. The Court Monitor will continue to monitor this repeat recommendation.

The draft RFQ that the Court Monitor has reviewed – in addition to the crisis beds noted above – also invites proposals for Residential "Low Barrier" Crisis Services for the Homeless. The targeted intent of this second proposal is to serve as a step-down for homeless persons needing stabilization, diversion from inpatient settings or shelter when too psychiatrically fragile to self protect from inclement weather. The

Court Monitor is certainly highly supportive of this second initiative as well, assuming that there are adequate funds available to do both.

C. *ACT Services*

The January 13, 2003 Report to the Court recommended that the DMH "should carefully review any and all barriers...that appear to be causing significant underutilization of ACT services." The concerns expressed at the time of the first Report to the Court remain – namely, that existing ACT Teams need to implement a full-blown ACT model and that the systemic barriers need to be removed (e.g., systematic identification of potential ACT clients, development of new ACT Teams, and the clear differentiation of the role of ACT Services vis-à-vis community support services).

This issue has taken on increased urgency for mental health advocates who have expressed frustration at the perceived lack of progress in this area. DMH is planning an ACT "summit" – an intense and focused meeting with a representative group that will focus on DMH providing clear direction and technical assistance in furthering the development of ACT and community support services, including assisting providers in the development of specific outcomes and timelines for achieving them. Also creating a sense of urgency is the fact that acute care admissions to St. Elizabeths continue to run high. While St. Elizabeths was unable to provide the Court Monitor with recidivism data, it is clear from national data that ACT Teams can and do have a direct impact on recidivism rates for ACT clients and also on overall inpatient days and days in the legal justice system.

The Court Monitor will track the progress in this critical area carefully. It is likely that a more in-depth review by the Court Monitor will occur to review specific plans and timetables that come out of the "summit" or any other DMH planning efforts.

D. *2003 Budget*

The January 13, 2003 Report to the Court outlined the impact of the $10.2 million reduction in the DMH 2003 Budget. The Court Monitor was assured that these reductions would not negatively impact the compliance with the Court-ordered Plan. At the time of this Report to the Court, there is nothing concrete or definitive that would argue against the DMH assertions. However, there are several areas of major concern that the Court Monitor will need to continue to track. These include:

1.) The DMH has requested the reprogramming of dollars into appropriate cost centers. This request for reprogramming went to the District Council for review and action on June 13, 2003. It will not impact the overall budget for DMH, but it will move $21.5 million primarily from the public CSA Cost Center to cover anticipated costs in the other major cost centers (St. Elizabeths; the Authority, and contracted CSA's). The Monitor was assured that the District CFO's office and the D.C. Council would be favorable to this request and would move toward approval on an expeditious basis.

2.) The larger issue is whether there will be – given current expense and revenue projections – adequate dollars for DMH to meet its obligations for 2003. Assuming that reprogramming occurs as discussed above, there is one other major issue that will to be critical for '03. The District — through the Office of Medicaid Public Provider Operations (OMPPOR) — has established a Reserve Fund to deal with District agencies that will likely experience shortfalls in'03 for Medicaid and/or Medicare billings. It should be noted that this short fall is not a result of DMH efforts or projections on the revenue side; nor is it an issue of DMH overexpending. Rather, the issue relates directly to the historical gross overprojections of revenue for the agency. DMH has an allocated total in this fund of $35.9 million potentially available. Based on current revenue projections, the DMH will need approximately $18.5 million of this reserve in order to balance its accounts for '03. DMH staff state that there is every indication that these reserve funds are readily available. The only question is when and how these dollars will be accessed – not if.

The summation for '03 is that the Court Monitor was assured that all anticipated revenues (including reprogramming and access to reserves) will be forthcoming and that there will not be a problem for DMH in '03 to meet all of its expense obligations – including contracted providers on a timely basis. The Court Monitor will closely track any and all issues as they impact the timely payment of obligations for '03.

E. Restructuring of Agency

In November 2002, the DMH publicly announced its plan to complete a major restructuring of the agency that was intended to align/realign the agency to comport with the community-centered thrust of the Court-ordered Plan. The original estimate was that up to 235 positions might be eliminated; in reality the final number was 182 positions. The reduction-in-force (RIF) was done in three distinct phases due to the fact that DMH – through its review of the D.C. Personnel Code – determined that it had three distinct organizational areas (St. Elizabeths, the Public CSA and the DMH Authority). The effect of

establishing distinct areas was that any displacement of employees (so-called "bumping") would only occur within the boundaries of each distinct area's workforce and not for the organization overall.

The three RIF's were completed in late March 2003. Of the 182 total positions abolished, the breakout and a brief analysis of impact is as follows:

1. **St. Elizabeths** – There were a total of 117 positions abolished, with 78 employees actually in these positions. Due to "bumping," 89 total employees were affected at St. Elizabeths or 6.8% of the total workforce. The major impact occurred in support areas (e.g., the trades positions) due to the consolidation onto the east campus. DMH has indicated that although some of the positions were clinical support positions (e.g., speech pathologists and physical therapy aides) none of the abolished positions were mainstream mental health professionals (i.e., nurses, social workers, psychologists and psychiatrists). Of the 78 abolished positions, 26 employees were eligible for retirement and 35 were eligible for severance pay.

2. **Public CSA** – The Public CSA abolished 20 positions, with 17 incumbents in these positions. Of the 17 incumbents whose positions were eliminated, eight were psychologists. The rationale for elimination of the psychologist positions was that measurable productivity standards were not being met and that the role of psychologists in a recovery-based model needed to be different (e.g., more emphasis on special treatment procedures and consultation to other team members). The net effect of both of these factors was determined to be a reduced need for psychologists. In addition, two encumbered Recreational Therapists were abolished and two Creative Arts Therapists were reassigned to Mental Health Specialist positions. Overall, the DMH determined that the eliminated positions would have a minimal impact on service delivery.

3. **Mental Health Authority** – The Authority abolished 45 positions, 20 of which were filled by incumbents. These positions represent almost 10% of the Authority workforce. The abolished positions at the Authority were determined not to be essential to meeting the Authority's priorities in meeting the mandates of the Court-ordered Plan.

Now that the RIF process has been completed, the Court Monitor would offer two broad comments. On the positive side, it does seem clear that the

restructuring was done with focus on the mandates of the Court-ordered Plan and was carried out with careful attention to the personnel rules in the District. The DMH indicates that it has added over 200 new functions in the three branches of the DMH as a result of the restructuring – all of these intended to meet the requirements of the Court-ordered plan and new federal and local obligations. While these rules and procedures served to lengthen the timeframe, it is hoped that any valid employee grievances and/or legal actions will be minimized as a result. It is also clear that the DMH took appropriate measures to reduce hardships on impacted employees. Of the 135 total employees affected, 19 found other jobs within the DMH or other District agencies, and 90 were eligible for either retirement or severance pay.

On the difficult side, the entire process of the RIF proved to be lengthy, complex and contentious. The DMH leadership had to spend considerable time defending its actions in front of the District Council, the media, etc. There is little question that internal morale suffered and that regaining employee trust will take some time. It is the Monitor's – and no doubt DMH's – hope that future workforce alignment can be accomplished in ways that are less traumatic and disruptive.

VI. Recommendations

The Court Monitor makes the following recommendations based upon the findings in the report:

A. The DMH has recognized that there is a significant gap between the number of persons "enrolled" in the new MHRS system and those who are truly "active." It is recommended that DMH take all necessary steps to close this gap via policy, information system upgrade or improved clinical engagement practices.

B. The DMH is strongly encouraged to develop the needed policies and implementation strategies to ensure that children/youth who go into residential care are enrolled into a CSA. This "clinical home" concept is key to active care management and continuity of care for children/youth.

C. The DMH – through the Office of Accountability – is encouraged to continue its "hands on" approach to those consumer complaints that are more complex, repetitive and often multi-agency in scope. As the provider oversight processes take shape (including the new grievance rule) it is critical that there be responsiveness and necessary clout at the Authority level to ensure that significant consumer issues are being addressed.

D. The DMH – and the District – must move aggressively to ensure that the Ervin Act is introduced to and passed by Congress. Given the delays, it is requested that the DMH keep the Court Monitor informed of progress on these efforts.

E. It is recommended that the DMH continue to find systemic ways (via policy changes, information systems interfaces, and internal business practices) to simplify and expedite contracts and timely payments to MHRS providers. While progress is noted, the current practices are unduly cumbersome and protracted.

F. The DMH needs to take all necessary steps to ensure that agreements/contracts with local acute care hospitals serving adults are negotiated and working. The current model of continued reliance on St. Elizabeths is not financially viable, does not promote the concept of community-integrated care, and is not in compliance with the Court-ordered plan.

G. The DMH should undertake a comprehensive review of the public CSA with an eye to its longer term viability. Initial issues – as discussed in the Court-ordered Plan – include legal and governance models, financial viability, systems capacity, etc. It is recommended that this analysis be shared – at appropriate intervals – with the Court Monitor for review and discussion.

H. The DMH must develop concrete plans (including timetables) to find an alternative site for CPEP. As noted in this report and the January 13, 2003 Report to the Court, the existing model does not comport with the intent of the Court-ordered Plan. The Court Monitor is willing to consider alternative models (e.g., enhanced mobile capacity) if developed and presented to the Court Monitor for review.

I. The DMH has not yet put in place any capacity for crisis residential beds, which is clearly contributing to increased admissions at St. Elizabeths. The DMH must move forward aggressively on this issue to ensure that this service is in place by September 1, 2003.

J. The DMH has undertaken a process to address the multiple issues regarding ACT services. These include the fundamental questions of whether persons needing ACT services are receiving them and whether the existing ACT teams are performing with fidelity to the ACT model and the DMH standards. It is strongly recommended that the DMH develop within the next 60 days a specific plan for improving ACT services. This plan – with specific timetables for action – should come to the Court Monitor for review and discussion.